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Department of Health

Communicable Diseases network AUSTRALIA

Coronavirus Disease 2019 (COVID-19)

CDNA National Guidelines for Public Health Units

Version 6.7

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Summary of revision history

For full revision history, refer to Appendix A

Version	Date	Revised by	Changes
6.7	22 March 2022	Communicable Diseases Network Australia	Updated: Release from isolation, Management of contacts
6.6	02 March 2022	Communicable Diseases Network Australia	Updated: Reinfection definition, Release from isolation criteria, Management of contacts
6.5	21 February 2022	Communicable Diseases Network Australia	Updated: Key definitions, The Disease, Routine prevention activities, Testing, Management of contacts, Special situations, Appendices
6.4	14 January 2022	Communicable Diseases Network Australia	Revisions to reflect National Cabinet decisions and AHPPC recommendations to revise test, trace, isolate and quarantine (TTIQ) in the context of high levels of COVID-19 transmission. Updated: Surveillance, Case definition, Testing, Case management, Release from isolation criteria, Close contact definition, Management of contacts
6.3	24 December 2021	Communicable Diseases Network Australia	Updated: Vaccination, Surveillance, Case investigation, Release from isolation criteria, Management of contacts, Aircraft passengers and crew, Appendix B
6.2	09 December 2021	Communicable Diseases Network Australia	Revisions to reflect emergence of the Omicron variant Updated: The Disease, Case definition, Genomic sequencing, Release from isolation criteria, Close contact definition, Management of contacts, Use of vaccination in outbreak situations, Appendix D (Table 4)
6.1	15 November 2021	Communicable Diseases Network Australia	Updated: Release from isolation criteria
6.0	08 November 2021	Communicable Diseases Network Australia	Revisions reflect ongoing community transmission in some Australian jurisdictions and progress through the phases of the National Plan to transition Australia's National COVID-19 Response.

These guidelines outline Australia's national minimum standard for surveillance, laboratory testing, case management and contact management for coronavirus disease 2019 (COVID-19). Jurisdictions may implement policies that exceed the national minimum standard based on local epidemiological context. CDNA will review and update these recommendations as new information becomes available on COVID-19 and the situation in Australia.

Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a public health specialist or other health professional. Clinical judgement and discretion may be required in the interpretation and application of these guidelines.

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Abbreviations

COVID-19:	Coronavirus disease 2019. The name of the disease caused by the virus SARS-CoV-2, as agreed by the World Health Organization, the World Organisation for Animal Health and the Food and Agriculture Organization of the United Nations. For more information, refer to the *WHO Director-General's remarks at the media briefing on 2019-nCoV on 11 February 2020*.
SARS-CoV-2:	Severe acute respiratory syndrome coronavirus 2. The formal name of the coronavirus that causes COVID-19, as determined by the International Committee on Taxonomy of Viruses. Previously, this coronavirus was commonly known as 'novel coronavirus 2019 (2019-nCoV)'. For more information, refer to the *Consensus Statement of the Coronaviridae Study Group of the International Committee on Taxonomy of Viruses*.

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1. Summary

These guidelines outline Australia's national minimum standard for surveillance, laboratory testing, case management and contact management for COVID-19. Jurisdictions may adapt this guidance based on local epidemiological context.

Guidance within this document reflects Australia's progress through the *National Plan to transition Australia's National COVID-19 Response* and the evolving COVID-19 situation in Australia.

Updates have been made in response to the National Cabinet's decision to *reset TTIQ measures in the context of high case numbers and the Omicron variant*, including the *usage of rapid antigen tests (RATs)*, as well as the *AHPPC statement on TTIQ in high levels of COVID-19 community transmission*.

Additionally, this document contains revised case and contact management guidance as detailed in the *National Cabinet agreed COVID-19 Test & Isolate National Protocols*.

CDNA has revised the guidance in this document for pragmatic reasons in response to a context of high case prevalence, altered policy settings and increased risk tolerance, and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

For detailed guidance on infection prevention and control, refer to *Infection Control Expert Group (ICEG) endorsed infection prevention and control guidance*.

Public health priority

Urgent – initiate public health responses as soon as possible. Public health responses may be automated and prioritised to assist with maintaining public health workforce capacity.

Case management

Confirmed cases must isolate according to isolation and restriction guidance until they meet the appropriate release from isolation criteria.

Hospitalised confirmed cases should be isolated in a negative pressure room with anteroom, where available. For guidance on infection prevention and control for routine care of confirmed COVID-19 patients, including personal protective equipment (PPE), *see ICEG-endorsed infection control guidance*.

Contact management

PHUs should manage close contacts according to management of contacts guidance.

2. Key definitions

Community transmission

Community transmission, in this guidance refers to when there are multiple COVID-19 cases in the community, where the source is unknown and presumed to have been acquired from another case within that jurisdiction.

Up-to-date COVID-19 vaccination status

Please note, for the purpose of being up-to-date in the Australian Immunisation Register (which does not contain any information on medical conditions), a total of 3 doses will be counted as being up-to-date. For more information see *ATAGI statement on defining up to date status for COVID-19 vaccination*.

For individuals aged 16 years and over

Receipt of homologous (same brand) or heterologous (different brand) primary schedule of 2 doses of any TGA approved or TGA recognised COVID-19 vaccine at least 14 days apart, except for Janssen COVID-19 Vaccine where only 1 dose is required AND receipt of a booster dose of a TGA approved vaccine (Pfizer, Moderna, or AstraZeneca) at a recommended interval of 3 months after receipt of the last dose of a primary schedule, and not later than 6 months (i.e. within 3 months of becoming eligible).

For individuals aged 5 to 15 years

Receipt of a homologous or heterologous primary schedule of two doses of any TGA approved or TGA recognised COVID-19 vaccine at least 14 days apart. A booster dose is currently not required. ATAGI will update advice on up-to-date status if and when boosters are recommended for children and adolescents in these age groups.

For immunocompromised aged 5 years and over

To remain up-to-date, severely immunocompromised individuals aged 5 years and over require an additional dose of a COVID-19 vaccine in the primary schedule, 2-6 months after the previous dose. Those aged 16 years and over are recommended a booster dose, 3 months after dose 3 of their primary vaccination course.

Reinfection

A subsequent confirmed SARS-CoV-2 infection in a person with a past known history of confirmed or probable COVID-19 that is determined to be a separate episode to the first based on epidemiological and/or laboratory findings. SARS-CoV-2 RNA detection must be greater than 12 weeks after release from isolation from the first infection to be considered reinfection. Reinfection requires confirmatory NAAT. Wherever feasible, whole genome sequencing should be undertaken for suspected reinfections.

COVID-19 death

A COVID-19 death is defined for surveillance purposes as a death in a confirmed or probable COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death. Where a Coroner's report is available, these findings are to be observed.

3. The disease

Infectious agent

SARS-CoV-2 is the infective agent that causes COVID-19. SARS-CoV-2 is a novel coronavirus that was first identified in humans in Wuhan, China, in December 2019. Human coronaviruses often cause mild illness in humans, such as the coronaviruses that cause the common cold. Animal coronaviruses can sometimes evolve to infect people and then spread between people resulting in serious epidemics. Mutations allowing human-to-human transmission have led to outbreaks of severe acute respiratory disease due to MERS-CoV and SARS-CoV.

Reservoir

The *WHO-convened Global Study of Origins of SARS-CoV-2: China Part* suggests bats and pangolins may be the reservoir for SARS-CoV-2. Further investigation is required to confirm the origin of SARS-CoV-2 (1).

Mode of transmission

SARS-CoV-2 can be transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces (2). While the exact relative contributions of these routes remains unclear, those who have been in close contact with a COVID-19 case are at highest risk (2).

Reproduction number and transmission dynamics

Estimates for the basic reproductive number (R_0) of early SARS-CoV-2 variants ranged from 2–4 (3). R_0 for confined settings were potentially at the higher end of this range.

Preliminary evidence indicates that the Omicron variant has a transmission advantage over previous variants in highly vaccinated populations likely due to immune escape and increased inherent transmissibility (4, 5).

SARS-CoV-2 variants of concern or interest

The Communicable Diseases Genomics Network (CDGN) actively monitors variants and their reported mutations to understand how they influence the behaviour of the virus.

Some variants are classified as ‘variants of concern’ (VOC), as there is evidence for epidemiological, biological, or immunological features of concern. Some SARS-CoV-2 VOC may be associated with increased transmissibility or higher mortality compared with other lineages (6, 7). Lineages for which there is no clear evidence that the mutations confer epidemiological, pathological or immunological features of concern may be denoted ‘variants under investigation’ or ‘variants of interest’.

For more information see*: PHLN statement on reporting of SARS-CoV-2 variants of concern and interest*.

Incubation period

The median incubation period is 5 to 6 days, with a range of 1 to 14 days (8-10). Around 1% of COVID-19 cases developed symptoms more than 14 days after exposure (11). Some studies

suggest that the incubation period of more recent SARS-CoV-2 variants may be shorter than wild type SARS-CoV-2 (12-14).

There is currently limited evidence to determine how the incubation period for breakthrough infection in vaccinated individuals may differ from infection in unvaccinated individuals.

Infectious period

Several studies have confirmed the occurrence of pre-symptomatic and asymptomatic transmission (15, 16). Pre-symptomatic transmission can occur 1-3 days before symptom onset (17, 18). Peak viral load in upper respiratory tract samples occurs most often around the time of symptom onset and declines after the first week following symptom onset (19).

Clinical presentation and outcome

The most common symptoms of COVID-19 are fever, cough, shortness of breath, sore throat and loss of smell or loss of taste. Other non-specific symptoms of COVID-19 include: fatigue, headache, runny nose, acute blocked nose (congestion), muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

Evidence suggests that the severity of infection with the Omicron variant is less than previous strains. Observational studies indicate that people infected with the Omicron variant are less likely to be hospitalised than patients infected with the previous variants (20).

Case fatality rate

As at 20 March 2022, the crude case fatality rate (CFR) for confirmed cases reported globally is approximately 1.3% (21). The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, including how this may change over time, especially for mild cases, and the impact of health systems and patient outcomes. Mortality is influenced by individual risk factors, vaccination status, and health care quality and access. As of 20 March 2022, a total of 5,730 COVID-19 deaths have been reported in Australia and 32.7% (1873/5730) of COVID-19 deaths have occurred in residential aged care facility residents who may be at higher risk of severe disease and death (based on aged care public dashboard data and surveillance data).

Persons at increased risk of exposure

People who have frequent, close, or extended contact with others have the potential for greater exposure to SARS-CoV-2.

People at increased risk of exposure include those who:

- Have travelled to areas with higher prevalence of COVID-19;
- Are caring for COVID-19 cases; or
- Come in contact with people with a higher likelihood of having active infection.

Other people at increased risk of exposure might include those in public facing occupations or crowded settings (e.g. hospitality, public transport, retail).

Persons who live or work in a high-risk setting, where there is evidence of a risk for rapid spread and ongoing chains of transmission, may also be at increased risk of exposure if an infectious case is introduced. Settings where disease is likely to readily transmit and be amplified are those with a high population density, settings where people are living or working in close proximity to others, or specific environmental conditions.

People at increased risk of severe disease

Older individuals are at the highest risk of severe COVID-19. Others with certain comorbidities are also at increased risk of severe COVID-19. Information on those at high and moderate risk of severe illness, and other factors that might increase the risk of severe disease, is available on the Department of Health's *Advice for people at risk of coronavirus (COVID-19)*.

4. Routine prevention activities

Vaccination

The COVID-19 vaccination program commenced in Australia on 22 February 2021. The overarching goal of the program is to protect all people in Australia from the harm caused by SARS-CoV-2, through preventing serious illness and death, and, as much as possible, disease transmission.

As of February 2022, the Australian Technical Advisory Group on Immunisation (ATAGI) recommends vaccination for all individuals aged 5 years and over in a two-dose vaccine schedule (3 doses for severely immunocompromised individuals) for the COVID-19 vaccines currently available in Australia. ATAGI recommends the use of a single booster dose for anyone aged 16 years and older who completed their primary COVID-19 vaccine course 3 or more months ago. For more information, see *Clinical guidance for COVID-19 vaccine providers* and *ATAGI statement on defining up to date status for COVID-19 vaccination*.

The COVID-19 vaccines registered for use in Australia have all been shown to be highly effective against severe disease, including previous SARS-CoV-2 variants of concern (22). There is very strong evidence that COVID-19 vaccination protects against severe disease due to the Omicron variant (23). Existing vaccine safety monitoring systems have been strengthened, with weekly COVID-19 vaccine safety reports provided by the Therapeutic Goods Administration and AusVaxSafety active surveillance system.

Other prevention activities

When combined, prevention and control activities can help limit the spread of certain respiratory diseases, including COVID-19. These measures may include:

1. Physical distancing and gathering
    - Physical distancing can reduce the potential for transmission. Physical distancing measures may include:
        - maintaining a distance of 1.5m from people
        - density restrictions; and
        - limits on the number of people allowed to participate in an event.
2. Environmental controls, such as optimised ventilation
3. Personal hygiene
    - PHUs should encourage good hygiene practices to prevent SARS-CoV-2 infection including:
        - wearing a face mask where physical distancing cannot be maintained, particularly indoors;
        - staying home if unwell;

- effective hand and respiratory hygiene; and
- cleaning surfaces

4. Travel restrictions
    - Some jurisdictions will require quarantine or testing of domestic and international travellers. See *COVID-19 FAQs- international travellers to Australia.*

5. Surveillance

There are five main objectives of surveillance for COVID-19, which are to rapidly:

1. Identify, isolate and manage cases.
2. Identify, quarantine and provide relevant information to contacts.
3. Detect and manage clusters and outbreaks.
4. Characterise the epidemiology of COVID-19 in Australia to inform the public health response including:
    - analysing the progression of the epidemic in time, person and place;
    - describing the transmission dynamics;
    - identifying groups at special risk of infection or more severe disease; and
    - monitoring for SARS-CoV-2 variants.
5. Monitor the effectiveness of the following routine prevention and control activities, in managing the COVID-19 outbreak over time:
    - vaccination;
    - test, trace, isolate and quarantine processes; and
    - public health and social measures.

Reporting

PHUs should immediately notify the central state/territory communicable diseases unit when notified of a confirmed case of COVID-19 or death in an infected person. Jurisdictions can determine reporting requirements for probable cases (e.g. requiring probable cases to self-report positive RAT results).

Where possible, PHUs should collect information regarding the case's age, sex, comorbidities, vaccination status, place of residence, occupation, Indigenous status, any culturally/linguistically diverse background, date of onset, travel history, laboratory results, clinical status and likely place of acquisition.

Central state/territory communicable diseases units will notify confirmed COVID-19 cases and deaths as soon as practicable to the Australian Government Department of Health via both transmission of data to the National Notifiable Diseases Surveillance System (NNDSS) and via email or telephone notification to the National Incident Room.

Data management

PHUs should enter initial information on confirmed cases of COVID-19 onto the jurisdictional notifiable diseases database, for transmission to the NNDSS, within one

working day of the notification/report. Enter enhanced surveillance data shortly after case follow-up. Jurisdictions are encouraged to prioritise and automate as many of these processes as possible, including linking COVID-19 cases to clinical services.

Surveillance of variants of concern

Early identification of cases, where there is a high probability of infection with a VOC such as the Omicron variant, can inform appropriate public health responses. Ideally, these VOC are identified through whole genome sequencing. Omicron primary test results with spike gene target failure may indicate probable infection with this variant. Where possible, public health reference laboratories should confirm the infecting strain using whole genome sequencing, although this may not be possible where large numbers of cases are occurring.

Jurisdictions can refer to the *CDGN Laboratory Case Definitions for SARS-CoV-2 Variants of Concern* for more information.

6. Cases

Definitions

Reporting

Notify confirmed cases in the jurisdiction of public health management. Jurisdictions can determine reporting requirements for probable cases.

People meeting the confirmed or probable case criteria who were previously diagnosed and managed overseas or in another Australian jurisdiction in the past 12 weeks[1] do not need to be re-notified. In this situation, the person should provide documented evidence of diagnosis overseas or interstate to the PHU.

Confirmed case

The confirmed case definition intends to capture newly diagnosed cases with laboratory definitive evidence to support a diagnosis.

A confirmed case requires laboratory definitive evidence.

Laboratory definitive evidence:

1. Detection of SARS-CoV-2 by nucleic amplification acid testing (NAAT);

OR

2. Isolation of SARS-CoV-2 in cell culture, with confirmation using a NAAT;

OR

3. SARS-CoV-2 IgG seroconversion or a four-fold or greater increase in SARS-CoV-2 antibodies of any immunoglobulin subclass including 'total' assays in acute and convalescent sera, in the absence of vaccination[2].

Probable case

A probable case includes individuals who have laboratory suggestive evidence

Laboratory suggestive evidence:

Detection of SARS-CoV-2 by rapid antigen testing (RAT)

[1] This time period has been recommended for pragmatic reasons. CDNA will review this recommendation as more evidence becomes available.

[2] Antibody detection must be by a validated assay and included in an external quality assurance program. For all serological responses to be counted as laboratory evidence, a person should not have had a previous COVID-19 vaccination.

Testing

Specimen collection and testing for SARS-CoV-2

Nucleic acid amplification testing (NAAT) (for example, using reverse transcription polymerase chain reaction (RT-PCR) or transcription-mediated amplification (TMA) is the gold standard for diagnosing acute symptomatic SARS-CoV-2 infection.

For advice on selecting a suitable sample for diagnostic NAAT for SARS-CoV-2, specimen handling in the laboratory and different types of SARS-CoV-2 specific testing, see *Public Health Laboratory Network (PHLN) guidance on laboratory testing for SARS-CoV-2.*

Guidance on Personal Protective Equipment (PPE) for specimen collection is available from *ICEG-endorsed infection control guidance*.

Rapid antigen tests

Rapid antigen tests (RATs) are an alternative testing method, providing fast results following the collection of a respiratory sample. The sensitivity of RATs are inherently lower than NAAT and performance of different RATs can vary from test to test.

In the context of widespread community transmission, PHLN and CDNA recommend deployment of RATs to enhance and preserve laboratory-based testing capacity. Specific guidance on the use of RATs is outlined in the *PHLN and CDNA joint statement on SARS-CoV-2 rapid antigen tests.* This statement describes how RATs may be effectively used to enhance Australia's COVID-19 response, while mitigating associated potential limitations and risks.

Guidance implemented may be decided at the discretion of the relevant state or territory in line with the *Testing Framework for COVID-19 in Australia*. The Testing Framework provides guidance on the use and appropriateness of different testing methods within four defined epidemiological zones.

Who to test for SARS-CoV-2

People who have at least one of the following COVID-19 like symptoms should test for SARS-CoV-2:

- Fever (≥37.5 °C) or history of fever (e.g. night sweats, chills); or
- Acute respiratory symptoms (e.g. cough, shortness of breath, sore throat); or
- Loss of smell or loss of taste.

Other non-specific symptoms of COVID-19 include: fatigue, headache, runny nose, acute blocked nose (congestion), muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

Testing following a possible vaccine-related adverse event

If a vaccine recipient has not had known contact with a confirmed COVID-19 case and develops fever, headache, fatigue or other mild systemic symptoms within and lasting for less than 48 hours after receipt of a COVID-19 vaccine in the absence of respiratory symptoms (including loss of smell), it is more likely that they have an expected vaccine response and testing may not be required.

If symptoms persist past 48 hours post vaccination, these individuals should get tested. For more information, see *Australian Technical Advisory Group on Immunisation (ATAGI) Clinical guidance on use of COVID-19 vaccine in Australia in 2021*.

Stay at home requirements after COVID-19 testing

Health care workers providing testing services should clearly communicate the following stay at home requirements after COVID-19 testing:

1. Symptomatic people who have tested for SARS-CoV-2 should stay at home until they receive a negative test, regardless of vaccination status.
2. Asymptomatic people who are not close contacts do not need to stay at home whilst awaiting a test result, unless instructed to stay at home by a public health authority.

See Management of Contacts for guidance on quarantine and testing of close contacts.

Assessing indeterminate and suspected false positive NAAT results

Indeterminate (equivocal) or suspected false positive results may occur due to low viral copy numbers; persistent shedding; or non-SARS-CoV-2 target reactivity in the NAAT.

Where feasible (i.e. in settings where laboratories are operating within their capacity), it is recommended that PHUs should contact the laboratory specialist microbiologist (pathologist) to discuss the results and decide whether further testing is required. Consider results in the context of the clinical and epidemiological circumstances to inform whether further laboratory or public health action is required.

For more information on indeterminate results and the possible sources of false positive NAAT results, see *PHLN Guidance on Nucleic Acid Test Result Interpretation for SARS-CoV-2*.

Case management

Response times

Confirmed cases:

For timely follow up of cases, PHUs should use automated case management systems that utilise self-managed contact tracing. Where feasible, jurisdictions may complete case interviews, exposure site identification and contact tracing by phone. Phone-based public health follow up would typically be used in situations where case numbers are very low, where new cases have been identified in settings previously without cases (such as remote communities), in some settings with vulnerable cases and contacts, and where SMS or other automated follow up is not practical.

In exceptional circumstances, some PHU staff may be required to contribute to the expert assessment of patients under investigation on hospital clinician or general practitioner request.

Probable cases:

Where feasible, conduct follow up of probable cases as per confirmed cases (see above).

Response procedure

Genomic sequencing

Genomic sequencing is an important part of SARS-CoV-2 surveillance and can be used to monitor transmission dynamics, identify lineages of concern, and inform outbreak investigation and public health response.

Where community transmission is established, it may not be justifiable to attempt to sequence every COVID-19 case. In these situations, PHUs should employ prioritisation strategies based on their jurisdiction's epidemiological context, capacity and priorities. This approach balances the costs and benefits of real-time SARS-CoV-2 genomic surveillance, where there is rapid spread of a dominant variant.

The *CDGN, PHLN and CDNA Sampling strategy for SARS-CoV-2 genomic surveillance* provides guiding principles and outlines an approach to selective and targeted sequencing. This includes guidance on priority groups for targeted sampling (e.g. international travellers).

For further information, see:

- *PHLN guidance on laboratory testing for SARS-CoV-2*
- *Testing Framework for COVID-19 in Australia*
- *Australian National Disease Surveillance Plan for COVID-19*

Case investigation

Where feasible, PHUs should respond to COVID-19 case notifications as soon as possible via a case interview. However, where public health capacity is exceeded, PHUs can automate and prioritise case investigation processes (e.g. SMS based questionnaires). This may include automated surveys to collect only essential information that will assist with risk stratification, prioritisation of cases for public health follow up and surveillance. Priority cases include people in high-risk settings or situations.

If automated case management systems are utilised, PHUs should direct cases to self-isolate and provide them with information on how to isolate from others in their residence and what supports are available. PHUs should also provide information detailing how to conduct case-initiated contact management and how to access medical care.

Clinical management

In the absence of pathogen-specific interventions, patient management largely depends on supportive treatment, and vigilance for and treatment of complications. For further advice on clinical management, see:

- *WHO*
- *National COVID-19 Clinical Evidence Taskforce*
- *Cochrane Library: Coronavirus (COVID-19)*

Prophylaxis against severe disease:

Proactive use of monoclonal antibody therapy in people at high risk of developing severe disease may help prevent hospitalisation if it is administered within the first five days of developing symptoms. PHUs, in conjunction with the local clinical team, can help identify

cases for clinical treatment early. For further information on emerging clinical treatments, see *National COVID-19 Clinical Evidence Taskforce*.

Education

PHUs should provide access to educational resources about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. PHU staff should make accessible a COVID-19 factsheet to cases and their household contacts.

Hospitalised COVID-19 patients

To minimise the risk of transmission from hospitalised COVID-19 patients, PHUs should encourage hospitals to undertake a system based risk assessment. Hospitals can manage risk by applying layered mitigations using the hierarchy of controls. This includes using a combination of:

- Elimination controls to reduce opportunities for staff exposure and transmission of the virus (e.g. reducing entry to patient rooms, excluding staff who are unwell and vaccinating staff).
- Engineering controls (e.g. optimising ventilation and using negative pressure rooms, where available).
- Administrative controls (e.g. through implementation of effective infection prevention and control policies and protocols).
- Appropriate use of PPE.

Hospitalised confirmed or probable cases should isolate in a negative pressure room with anteroom, where available. If a negative pressure room is not available, the hospitalised case can isolate in a standard isolation room or single room with negative airflow as an alternative. Avoid rooms with positive pressure airflow.

If there is concern about a potential exposure related to a hospitalised case, PHUs should assist with providing resources to support risk assessment of hospital staff, visitors or other patients to determine whether further public health response is required (See Health and residential care workers).

For further guidance on infection prevention and control, including PPE, see ICEG-endorsed infection control guidance.

Release from isolation

Release from isolation criteria for all confirmed or probable cases

The following table details release from isolation criteria for all confirmed or probable cases as outlined in the *National Cabinet agreed COVID-19 Test & Isolate National Protocols*.

Revisions have been made for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

To calculate the isolation period, day 0 is the day the case took their first positive test. Day 1 is the first full day after the first positive test was taken.

Summary of release from isolation criteria agreed by National Cabinet[3]	
Asymptomatic case	If they remain asymptomatic after 7 days have passed since their first positive test, the case can be released from isolation.
Symptomatic case	If acute respiratory symptoms[4] resolve after 7 days since their first positive test, the case can be released from isolation. If acute respiratory symptoms are not resolved after 7 days since their first positive test, the case should remain isolated until their acute symptoms have resolved.

In addition to the above criteria, in some high-risk clinical settings, confirmed cases who are significantly immunocompromised[5] may be requested to meet the below additional criteria:

- Negative NAAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 7 days have passed since the first positive test; OR
- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 14 days have passed since the since the first positive test.

[3] Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

[4] Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. Others may have on-going sequelae that result in symptoms such as continuing shortness of breath or post viral cough. For these people, the treating medical practitioner can make an assessment as to whether the respiratory signs and symptoms of acute COVID-19 have resolved.

[5] Persons who are clinically assessed as being significantly immunocompromised may have a reduced ability to effectively clear SARS-CoV-2 and a prolonged infectious period. Significantly immunocompromised persons may include, but are not limited to, those who: have had an organ transplant and are on immune suppressive therapy; have had a haematopoietic stem cell transplant in the past 2 years; are on immune suppressive therapy for graft versus host disease; have had an active haematological malignancy; human immunodeficiency virus infection with CD4 T-lymphocyte count below 200 cells/per mm^3; are receiving dialysis; or other conditions specifically noted by the treating medical practitioner.

Testing after release from isolation

Recovered cases do not need to be retested within 12 weeks[6] after release from isolation, regardless of symptoms.

If 12 weeks have passed after release from isolation, recovered cases should be tested for SARS-CoV-2 if they develop new COVID-19 symptoms and managed as a close contact if they meet the close contact definition.

Release from isolation and high-risk settings

Cases returning to a high-risk setting can be released from isolation based on the above criteria and do not need to meet a higher standard/ additional assessment before going into any high-risk settings. This includes persons returning to work in a health care setting, living in a residential aged care facility, or who regularly attend health care settings for any other reason. Specifically, if a person has met RFI criteria, it is not necessary for them to:

- undergo isolation or quarantine in another ward, the facility they are returning to, or any other location, or
- have evidence of any negative test results for SARS-CoV-2 prior to returning to residential aged care or any other setting.

However, there is some laboratory based evidence that a small proportion of people with a previous SARS-CoV-2 variant infection may still be infectious despite fulfilling RFI criteria.

Hospitalised patients who are being transferred to another ward or hospital should remain in isolation with transmission-based precautions and appropriate PPE until release from isolation criteria are met. People who have recovered from COVID-19 and have been released from isolation based on the criteria above do not require COVID-19 testing if they are hospitalised for a non COVID-19 related condition.

As a precaution, all recovered cases should continue following community recommendations (e.g. physical distancing, hand hygiene, masks where indicated, etc.) and health care workers should continue to use appropriate PPE as recommended when caring for COVID-19 patients, or in settings of potential exposure. Infectious cases living in the same household as recovered cases should remain isolated from recovered cases to the extent practicable.

[6] This time period has been recommended for pragmatic reasons. CDNA will review this recommendation as more evidence becomes available.

7. Contacts

Close contact definition

The aim of contact tracing is to interrupt transmission of SARS-CoV-2 through identification and quarantining of people in contact with infectious cases. PHUs can use the below close contact criteria to identify and prioritise people who have been exposed and potentially incubating the disease.

The following definitions have been adapted from the definition outlined in the *National Cabinet agreed COVID-19 Test & Isolate National Protocols*.

Revisions have been made for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous definitions have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

Contact classification[7]	Type of contact made during the case's infectious period
Close contact	A person who resides with or stays overnight in the same premises or has had more than 4 hours of cumulative contact with a COVID-19 case in a residential setting[8]. In exceptional circumstances or where a significant transmission event has occurred, PHUs may consider classifying additional persons as close contacts.
Other contact	A person who has been exposed to a COVID-19 case but does not meet the definition of a close contact.

Some jurisdictions have developed risk matrices for classification of close contacts in certain settings (e.g. for schools, workplaces). The rationale for risk assessment guidance is to balance COVID-19 transmission risk with the risk of furloughing staff to the extent that the business becomes non-operational. Such guidance will take account of specific risk mitigations within the operation of the business.

Note that:

- For contact tracing, the infectious period is considered to be the period extending from 48 hours before onset of symptoms in the case until the case is classified as no longer infectious (refer to Release from isolation).

[7] Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

[8] A residential setting is a building or a part of a building where individuals: spend the night for sleeping; including a house, apartment, or other private dwelling, and share facilities for acts of daily living which have the potential to create exposure between co- residents.

Residential settings may include: aged care facilities, military residential settings, boarding schools, boarding houses, homeless shelters, and maritime vessels

- If the case is asymptomatic, the infectious period is the period extending from 48 hours before the initial positive test until the case is classified as no longer infections (refer to Release from isolation).
- For guidance on individual risk assessment of workers in health care settings, including recommended work permissions and restrictions as determined by risk, see Health and residential care workers.

Management of contacts

Jurisdictions may devolve contact management practices to other methods such as automated identification and management of contacts. Jurisdictions may also provide public information to support self-managed contact tracing, testing and quarantine. PHUs may direct cases to follow up their own contacts and tell them to follow relevant public health advice.

Quarantine and testing of close contacts

Close contacts who have recovered from COVID-19 do not need to quarantine if:

- they remain asymptomatic;
- they are not immunocompromised; and
- re-exposure is less than 12 weeks since release from isolation (see Testing after release from isolation).

The following table has adapted the quarantine and testing requirements outlined in the *National Cabinet agreed COVID-19 Test & Isolate National Protocols*.

Revisions have been made to quarantine and testing requirements for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

To calculate the quarantine period, day 0 is considered the date that the first positive sample was collected from the primary case. Day 1 is the first full day after the primary case's positive test was taken.

Regardless of whether any new cases are identified in the household, all household close contacts will undertake a static 7-day quarantine period, with day 0 being the date that a positive sample was collected from the primary case, or for household-like contacts, the date of last exposure to the COVID-19 case.

Contact classification	Testing recommendations and quarantine requirements[9] (regardless of vaccination status)
Close contact	**Testing recommendations** • RAT/NAAT if symptoms develop • RAT on day 1 of quarantine • RAT on day 6 or 7 of quarantine

[9] Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

	Quarantine requirements
	• Quarantine for 7 days after the day the primary case took their first positive test (or date of last exposure to the primary case for household-like contacts) and monitor for COVID-19 symptoms.
	• If the day 6 or 7 RAT is negative and the close contact has no symptoms, they can exit quarantine at day 7.
	• If a close contact has symptoms and they return a negative RAT, the close contact should get a NAAT as soon as possible. If it is not feasible to get a NAAT, the close contact should get a second RAT 24 hours later.
	• If a positive RAT or NAAT is returned at any time during quarantine, the close contact should isolate until they meet the release from isolation criteria.
	Other recommendations
	• In the 7 days after exiting quarantine:
	  ○ Wear a mask when outside home.
	  ○ Monitor for COVID-19 symptoms. If the close contact becomes symptomatic, the close contact should isolate and be tested (RAT or NAAT).
	  ○ Where applicable, follow the requirements and guidance of high-risk settings.

Other contact	**Quarantine requirements** • No quarantine is required. **Other recommendations** • Monitor for symptoms for 14 days following exposure to a COVID-19 case. Where feasible, get a RAT/NAAT if symptoms develop. • If a positive RAT or NAAT is returned at any time within the 14 days following exposure to a COVID-19 case, the close contact should isolate until they meet the release from isolation criteria.

Health care and essential workers

For guidance on work permissions and restrictions for essential workers, PHUs can refer to the *National Cabinet's Interim Guidance on Permissions and Restrictions for Essential Workers*. This essential workers interim guidance outlines a process to support decision making when determining whether to place work permissions/restrictions on an essential worker who is subject to isolation or quarantine. This guidance presents a pragmatic approach to reduce the impact on workforce availability caused by increased case numbers and transmissibility of the Omicron variant.

The interim guidance has been developed by National Cabinet, taking into consideration the current context of the pandemic, including significant vaccination coverage in Australia, the commencement of booster vaccination, the emergence of Omicron, and likely future

progression. The interim guidance aims to allow for greater flexibility in balancing the need to reduce transmission against workforce shortages and consequent impacts on essential services.

For guidance on health care specific settings, PHUs can refer to *Permissions and Restrictions for Workers in Health Care Settings – Interim Guidance* for guidance on individual risk assessment of workers in health care settings, including recommended work permissions and restrictions as determined by exposure risk.

Medical care for quarantined individuals

PHUs should advise close contacts that if they require medical attention for any reason (e.g. fever and respiratory symptoms or other illness/injury), they should telephone their GP or hospital Emergency Department and advise them of their close contact status before presenting. Close contacts with severe symptoms should call 000 and clearly communicate to the emergency services operator that they are a close contact. Close contacts should wear a mask before presenting to any health care setting.

Education

Close contacts should be counselled about their risk and the symptoms of COVID-19 and provided with a COVID-19 factsheet. They should be given advice about the need to immediately self-isolate and get tested should they develop symptoms and given information about where and how to access COVID-19 testing.

8. High-risk settings

Residential care facilities

Outbreaks of COVID-19 in residential care facilities should be managed with close reference to the *CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.* These guidelines provide specific advice on the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.

Outbreaks of COVID-19 in congregate disability accommodation settings should also be managed with reference to the *CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services – The Disability Supplement*. These guidelines add tailored advice to support disability residential service providers and public health authorities to respond to the risk and occurrences of COVID-10 outbreaks in these settings.

Aboriginal and Torres Strait Islander Communities

CDNA will continue to monitor the emerging evidence around COVID-19 transmission risks in Aboriginal and Torres Strait Islander communities and revise these recommendations as needed. For further information, refer to the *CDNA National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19* and *CDNA National Guidance for Urban and Regional Aboriginal and Torres Strait Islander Communities for COVID-19*.

Correctional and detention facilities

Correctional and detention facilities may have existing frameworks and protocols in place for testing and isolation in the event of a communicable disease outbreak. Correctional and detention facilities should prepare for and manage outbreaks of COVID-19 with close reference to the CDNA *national guidelines for the prevention, control and public health management of COVID-19 outbreaks in correctional and detention facilities in Australia*.

Meat processing facilities

Meat (including poultry) processing facilities may present a higher risk of COVID-19 transmission to workers. These workplaces are vulnerable for a number of reasons including: production line work in close proximity to others; limited hygiene measures due to tally driven work; temperature and humidity; and employer sponsored communal housing and transport.

PHUs may assist work health and safety representatives to implement measures aimed at mitigating risk of COVID-19 exposure. Further information on COVID-19 in these facilities is available in Work Safe Victoria's recommendations for *Managing the risk of COVID-19 exposure: meat and poultry processing*. PHUs may also refer to the US Centers for Disease Control's *Facility Assessment Tool for Meat and Poultry Processing Facilities* to conduct an assessment of infection prevention and control measures within the facility.

9. Special situations

Use of COVID-19 vaccination in outbreak situations

Targeted vaccination of defined populations who may be at risk of exposure is an important activity complementing existing public health interventions. Targeted vaccination may increase the proportion of people who have received one dose, are fully vaccinated, or have received a booster dose of a COVID-19 vaccination (where eligible).

In an outbreak, PHUs can use COVID-19 vaccination to:

1. Reduce the number and severity of COVID-19 cases in an outbreak, where there is likely to be an ongoing risk of exposure.
2. Opportunistically increase vaccination uptake in the population through timely messaging around the benefits of vaccination.

Key considerations about using COVID-19 vaccines during outbreaks include: the location, target population, context of the outbreak, local epidemiology of COVID-19, and timing of potential exposure.

Vaccination as an outbreak response tool is of greatest use in geographic areas or populations with low vaccination coverage. However, public communications should emphasise the importance of people getting vaccinated even in areas of high coverage.

PHUs can also use COVID-19 vaccination in closed settings where there is an ongoing risk of exposure due to multiple chains of transmission. Example settings include residential aged care facilities, correctional facilities, remote industrial sites (e.g. mining camps) or educational institutions.

In these contexts, vaccination may provide both direct protection against severe illness and death, and indirect protection by limiting outbreak size and duration.

Where possible, PHUs should evaluate the effectiveness of vaccination campaigns in limiting the impacts of COVID-19 at the conclusion of the outbreak.

Schools

Schools and Early Childhood Education and Care (ECEC) facilities may implement a variety of strategies to reduce COVID-19 transmission, including:

- Cohorting and staggering class schedules
- Use of RAT (either for symptomatic people or routine screening)
- Mask wearing at relevant ages
- Improvement in ventilation/teaching in outdoor settings where feasible
- Optional hybrid or remote learning

Schools and ECEC facilities are responsible for implementing risk mitigation strategies and outbreak response plans in line with jurisdictional guidance.

Jurisdictions have developed operational plans for schools, taking into consideration the objectives and guiding principles of the *National Framework for Managing COVID-19 in Schools and Early Childhood Education and Care (ECEC)*. Key objectives outlined in this framework include protection of vulnerable students and staff at higher risk of severe

disease, minimising disruption to face-to-face learning, minimising transmission and minimising broader workforce disruptions for parents and carers.

Jurisdictions may also recommend additional measures for boarding schools due to increased transmission risk and consequences associated with infection. This may involve requiring boarding schools to have clear isolation/quarantine plans in place and clear messaging to parents and carers about the risks associated with boarding.

International travellers

For information on international travel, pre-flight testing and travel requirements, see *International travel and COVID-19* and *Coronavirus (COVID-19) FAQs – international travellers to Australia*.

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11. Appendix A: Full revision history

Version	Date	Revised by	Changes
6.7	22 March 2022	Communicable Diseases Network Australia	Updated: Release from isolation, Management of contacts
6.6	02 March 2022	Communicable Diseases Network Australia	Updated: Reinfection definition, Release from isolation criteria, Management of contacts
6.5	21 February 2022	Communicable Diseases Network Australia	Updated: Key definitions, The Disease, Routine prevention activities, Testing, Management of contacts, Special situations, Appendices
6.4	14 January 2022	Communicable Diseases Network Australia	Revisions to reflect National Cabinet decisions and AHPPC recommendations to revise test, trace, isolate and quarantine (TTIQ) in the context of high levels of COVID-19 transmission. Updated: Surveillance, Case definition, Testing, Case management, Release from isolation criteria, Close contact definition, Management of contacts
6.3	24 December 2021	Communicable Diseases Network Australia	Updated: Vaccination, Surveillance, Case investigation, Release from isolation criteria, Management of contacts, Aircraft passengers and crew, Appendix B
6.2	09 December 2021	Communicable Diseases Network Australia	Revisions to reflect emergence of the Omicron variant Updated: The Disease, Case definition, Genomic sequencing, Release from isolation criteria, Close contact definition, Management of contacts, Use of vaccination in outbreak situations, Appendix D (Table 4)
6.1	15 November 2021	Communicable Diseases Network Australia	Updated: Release from isolation criteria
6.0	08 November 2021	Communicable Diseases Network Australia	Revisions to reflect ongoing community transmission in some Australian jurisdictions and progress through the phases of the National Plan to transition Australia's National COVID-19 Response.
5.1	08 October 2021	Communicable Diseases Network Australia	Revised: Contact management- Casual contacts
5.0	06 October 2021	Communicable Diseases Network Australia	Inclusion of new guidance: Appendix C- Work Permissions and Restrictions Framework for workers in health care settings. Revised: Case definition, Enhanced testing, Contact management- Casual contacts
4.8	07 September 2021	Communicable Diseases Network Australia	Revised: Testing, Case management, Close contact definition, Contact management
4.7	24 June 2021	Communicable Diseases Network Australia	Revised: Case definition, Release from isolation criteria, Contact management
4.6	16 June 2021	Communicable Diseases Network Australia	Revised: The Disease, Testing, Case Management
4.5	26 May 2021	Communicable Diseases Network Australia	Inclusion of new guidance: Use of COVID-19 vaccination in outbreak situations Revised: Special situations

Version	Date	Revised by	Changes
4.4	11 May 2021	Communicable Diseases Network Australia	Inclusion of new appendix: Appendix B: Outbreak investigation and management Revised: Summary, The Disease, Case definition, Testing, Case Management, Release from Isolation, Management of contacts, High-risk settings
4.3	03 March 2021	Communicable Diseases Network Australia	Revised: The Disease, Case Definition, Testing, Case Management, Release from Isolation, Close contacts, Outbreak investigation and management in high-risk settings, Special situations, Appendix B Inclusion of new section: Appendix C
4.2	29 January 2021	Communicable Diseases Network Australia	Revised: Case definition
4.1	12 January 2021	Communicable Diseases Network Australia	Inclusion of new subsection: Prioritisation of whole genome sequencing for all cases Revised: Case management with inclusion of subsection detailing management of cases infected with a SARS-CoV-2 variant
4.0	23 December 2020	Communicable Diseases Network Australia	Modifications to meet a setting of low prevalence of disease in Australia. Inclusion of new sections: Close contact definitions, Appendix D. Revised: The disease, Routine prevention activities, Case definition, Laboratory testing, Case management, Contact management, Outbreak investigation and management in high-risk settings, Appendix C
3.11	10 December 2020	Communicable Diseases Network Australia	Revised: Summary, The disease, Case definition, Case management, Special risk settings, Appendix A
3.10	28 October 2020	Communicable Diseases Network Australia	Revised: The disease, Laboratory testing, Release from isolation, Contact management, Appendices
3.9	09 October 2020	Communicable Diseases Network Australia	Revised: The disease, Release from isolation, Outbreak investigation and management in high-risk settings, Special risk settings, Special situations.
3.8	23 August 2020	Communicable Diseases Network Australia	Revised: Modes of transmission, Release from isolation, Close contact definition – notes.
3.7	12 August 2020	Communicable Diseases Network Australia	Revised: Enhanced testing. Inclusion of new Special situations sub-section: Workplaces. Inclusion of new Special risk settings sub-section: Meat processing facilities.
3.6	30 July 2020	Communicable Diseases Network Australia	Revised: Case definition – Enhanced testing, Contact management.
3.5	24 July 2020	Communicable Diseases Network Australia	Inclusion of new section: Routine prevention activities. Inclusion of new Laboratory testing sub-section: Procedure for assessing indeterminate and suspected false positive SARS-CoV-2 PCR results.
3.4	01 July 2020	Communicable Diseases Network Australia	Revised: Case definition – suspect case, The disease, Communications, Laboratory testing, Case management, Appendix A, Appendix B, Appendix D. Minor wording changes in other sections.
3.3	22 June 2020	Communicable Diseases Network Australia	Revised: Case definition – enhanced testing, Case management – definition of COVID-19 death

Version	Date	Revised by	Changes
3.2	12 June 2020	Communicable Diseases Network Australia	Revised: Case definition – suspect case clinical criteria.
3.1	04 June 2020	Communicable Diseases Network Australia	Revised: Laboratory testing, Case management – Release from isolation, Contact management.
3.0	28 May 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Appendix B. Inclusion of new section: 11. Outbreak investigation and management in high-risk settings.
2.11	22 May 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Contact management.
2.10	13 May 2020	Communicable Diseases Network Australia	Inclusion of new sections: Appendix C, Appendix D, Appendix E. Revised sections: The disease, Communications, Case definition – inclusion of serology, Laboratory testing, Case management, Contact management, Special risk settings, Special situations, Appendix A.
2.9	05 May 2020	Communicable Diseases Network Australia	Revised: Case definition – clinical criteria.
2.8	01 May 2020	Communicable Diseases Network Australia	Inclusion of new sections: Summary, The disease, Surveillance, Communications, and Data management. Revised: Case definition, Laboratory testing Case management, Contact management, Special risk settings, Special situations, Appendix A, and Appendix B.
2.7	24 April 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management.
2.6	17 April 2020	Communicable Diseases Network Australia	Revised: Case management, Contact management – Close contact definition.
2.5	06 April 2020	Communicable Diseases Network Australia	Revised: Case definition.
2.4	26 March 2020	Communicable Diseases Network Australia	Inclusion of advice for probable cases throughout.
2.3	24 March 2020	Communicable Diseases Network Australia	Revised: Case definition.
2.2	21 March 2020	Communicable Diseases Network Australia	Revised: Case management – Release from isolation.
2.1	20 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management, Special situations.
2.0	13 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management, Laboratory testing, Appendix A.
1.18	10 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Contact management. Inclusion of Aircrew and Schools advice in Special situations section.

Version	Date	Revised by	Changes
1.17	05 March 2020	Communicable Diseases Network Australia	Inclusion of self-quarantine advice for returned travellers from South Korea, revised Case management, inclusion of table of contents.
1.16	04 March 2020	Communicable Diseases Network Australia	Inclusion of Aboriginal and Torres Strait Islander community advice in Special situations section.
1.15	03 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management.
1.14	02 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Risk stratification of countries, Contact management.
1.13	28 February 2020	Communicable Diseases Network Australia	Revised: Laboratory testing, isolation and restriction and Appendix A: laboratory testing information.
1.12	27 February 2020	Communicable Diseases Network Australia	Inclusion of Cambodia in the list of countries in the Person under investigation section.
1.11	26 February 2020	Communicable Diseases Network Australia	Inclusion of Italy in the list of countries in the Person Under Investigation section.
1.10	23 February 2020	Communicable Diseases Network Australia	Inclusion of South Korea and Iran in the list of countries in the Person Under Investigation section.
1.9	21 February 2020	Communicable Diseases Network Australia	Revised: case definition, infectious period, contact management, special situation (cruise ship). Specific changes are highlighted.
1.8	17 February 2020	Communicable Diseases Network Australia	Inclusion of statement reflecting that passengers of the Diamond Princess cruise meet the criteria for close contact.
1.7	15 February 2020	Communicable Diseases Network Australia	Revised case definition.
1.6	14 February 2020	Communicable Diseases Network Australia	Addition of Appendix B: Interim recommendations for the use of personal protective equipment (PPE) during hospital care of people with Coronavirus Disease 2019 (COVID-19). Updated nomenclature.
1.5	07 February 2020	Communicable Diseases Network Australia	Inclusion of advice on release from isolation.
1.4	06 February 2020	Communicable Diseases Network Australia	Revised case definition and added rationale. Updated infection control advice throughout.
1.3	04 February 2020	Communicable Diseases Network Australia	Revised the case definition and use of the terms ‘quarantine’ and ‘isolation’.
1.2	02 February 2020	Communicable Diseases Network Australia	Revised the case definition, close and casual contact definitions and added self-isolation guidance.
1.1	27 January 2020	Communicable Diseases Network Australia	Removed references to Wuhan and revised the case definition.
1.0	23 January 2020	Communicable Diseases Network Australia	Developed by the 2019-nCoV Working Group.